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ORTHO OPNTE

* Final Report *

LONG, LYNDSEY SHANESE - TEC_00013896543

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*** Final Report ***

Patient Demographics

Name: LONG, LYNDSEY SHANESE

Sex: Female

Date of Birth: 04/26/1986

MRN: TEC_00013896543

FIN: 10005068081

ORTHO OPNTE

THE EMORY CLINIC, INC.
AMBULATORY SURGERY CENTER

PREOPERATIVE DIAGNOSIS:

Right knee medial and lateral meniscal tear.

POSTOPERATIVE DIAGNOSIS:

Right knee medial and lateral meniscal tear.

PROCEDURE PERFORMED:

Right knee arthroscopy with partial medial and lateral meniscectomy.

ASSISTANT:

Michelle Perry, ATC.

ANESTHESIA:

General with LMA.

ESTIMATED BLOOD LOSS:

Minimal.

TOURNIQUET TIME:

None.

FLUIDS:

Printed by: Williams, Brandi

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Please refer to the anesthesia record.

SPECIMENS:

None.

IMPLANTS:

None.

FINDINGS:

1. A radial-complex tear at the body and posterior horn of the medial meniscus involving approximately 15% of the medial meniscal surface area.
2. Tearing and fraying of the inner rim of the lateral meniscus at its body and posterior horn involving 10% of the meniscal surface area.
3. Stable grade 2-3 chondromalacia lateral tibial plateau involving approximately 33% of its articulating surface area.

COMPLICATIONS:

None.

CONDITION/DISPOSITION:

Stable, extubated to postanesthesia recovery.

BRIEF INDICATION FOR PROCEDURE/HISTORY OF PRESENT ILLNESS:

The patient is a 34-year-old female who continues to have pain and discomfort in her right knee. She is not significantly better with the usual nonoperative treatments. She has a history, physical examination, as well as imaging studies reviewed in my office consistent with the above-mentioned preoperative diagnosis. For that reason, the patient and I have had discussion regarding the risks, benefits, alternatives, and continued nonoperative care of the right knee versus a left knee arthroscopy with likely partial meniscectomy as indicated. The patient wanted to proceed. She knew that there were no guarantees given. She seemed to understand the expected postop recovery course. She knew that this was not a procedure intended to address durably any arthritic findings that I might encounter at the time of surgery. She knew that I could reliably take care of the meniscal tear and any associated mechanical symptoms. She denied any personal or family history of blood clot or bleeding tendency.

DESCRIPTION OF PROCEDURE:

The patient was identified in the preoperative holding area. Her operative right knee was initialed with the surgeon's initials. She was given 2 g of Ancef for routine infection prophylaxis. SCD boots were placed on the contralateral left lower extremity for DVT prophylaxis.

The patient was then taken back to the operating room. She was placed supine on the operating room table. A general anesthetic was then administered and an airway-securing LMA device placed by the anesthesiology team without obvious complication. Examination of the patient's right knee under anesthesia was unremarkable. The patient had a normal range of motion of the knee with a completely stable ligamentous examination.

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The patient's right lower extremity was then prepped and draped in the usual hospital sterile fashion. A time-out procedure was also completed. A standard inferolateral arthroscopic viewing portal was then established. The arthroscope was inserted atraumatically into the joint space. Examination of the suprapatellar pouch, as well as the medial and lateral gutters with the knee both flexed as well as extended did not reveal any loose bodies or pathology.

Examination of the patellofemoral joint was also undertaken. The cartilage surfaces of the patellofemoral joint were intact. The patella tracked normally without excessive tilt.

The medial compartment was then examined with the knee in flexion as well as valgus. An accessory inferior medial working portal was also established using an outside-to-in technique. This was done under direct visualization. A probe was then inserted and a radial-complex tear at the body and posterior horn of the medial meniscus was identified. It was clearly unstable. Thus, I used an arthroscopic basket and shaver device to perform a partial medial meniscectomy back to a stable healthy rim of medial meniscal tissue. The articular cartilage in the medial compartment was well preserved.

The intercondylar notch was then examined. The ACL was found to be intact. The PCL appeared to be normal as well.

The lateral compartment was then examined with the knee in a figure-4-type position. The lateral meniscus was probed from anterior to posterior both superiorly and inferiorly and found to be torn and frayed at its inner rim at the body and posterior horn. Thus, I used a meniscal basket and shaver device to perform a partial lateral meniscectomy back to a stable healthy rim of lateral meniscal tissue. There was moderate grade chondromalacia changes of the lateral tibial plateau as noted above. I did probe these areas though and found them not at all to be unstable.

At this point, I took an additional look around the knee. There was no further pathology. We had excellent hemostasis as well. Thus, I removed the arthroscope from the joint. I drained the knee of residual arthroscopic fluid. Simple nylon stitches were used to close the arthroscopic portal sites. Local anesthetic was injected around the portal sites, but not intra-articularly. Sterile dressings were placed about the knee followed by an Ace wrap. The patient had a palpable pulse on the dorsum of the foot and soft compartments about her right lower extremity. She was awakened from anesthesia and had the airway-securing LMA device removed. She was taken on a stretcher to postanesthesia recovery unit in stable condition. All sponge and instrument counts were correct.

Signature Line

Electronically Signed by: Lee, Gregory H, MD on 10.22.20.03:45 PM